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AMERICAN COLLEGE of SURGEONS

VOL. IV JANUARY, 1920 NO. 4

HOSPITAL STANDARDIZATION SERIES

GENERAL HOSPITALS OF 100 OR MORE BEDS

REPORT FOR 1919

AMERICAN COLLEGE OF SURGEONS
25 EAST WASHINGTON STREET, CHICAGO

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UNIVERSITY OF TORONTO

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HOSPITAL STANDARDIZATION SERIES

GENERAL HOSPITALS OF 100 OR MORE BEDS

REPORT FOR 1919

BY
JOHN G. BOWMAN
Director of the College

AMERICAN COLLEGE OF SURGEONS
25 EAST WASHINGTON STREET, CHICAGO

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HOSPITAL STANDARDIZATION

THE American College of Surgeons, at its beginning in 1913, included among its purposes the betterment of medical education and of the clinical practice of medicine. It recognized that matters of public health, the prevention of disease, and the intelligent distribution of the benefits of medicine are inseparable from these purposes. Work in these fields is known as hospital standardization. The following pages are a report of progress for the year 1919.

The administrators of the College took up hospital standardization with no preconceived idea or theory as to what should be done. They decided to study actual conditions, to find out what the normal processes of growth are and how these processes could be given speed. No "announcements" were made of this plan. But for two years a preliminary analysis was quietly pursued.

During these two years the College accumulated data from hospital folk and doctors; also the judgments of these groups as to what work could most wisely be undertaken, all of which served as a basis of procedure. These "assets" were gathered from every state in the Union and from every province in Canada. They grew out of conferences with hospital staffs, with city, county, and state medical societies, with superintendents, and with hospital trustees. In other words, the program of the College was built upon the cumulative wisdom of those concerned with it. As the climax to this preliminary work, the State Committees on Standards met in Chicago on October 19 and 20, 1917; and out of this conference grew the General Hospital Committee which met in Washington, December 8 and 9, 1917. Some details of these two meetings are given on page 11 herewith following.

After these two meetings the program of the College took more concrete form. That program was, first, to define a Minimum Standard; second, to enlist the co-operation of the hospitals in the fulfillment of the Standard, this work to be accomplished through personal visits to the hospitals by Staff members of the College; and third, to publish from time to time the list of hospitals throughout the two countries which fulfilled the Minimum Standard. The publication of the list, however, was not to occur until the hospitals themselves generally approved of such publication, each hospital having been given full opportunity to meet the Standard under normal conditions. The College anticipates at this time the publication in October, 1920, of a list of the general hospitals of 100 or more beds which fulfill the Standard. A similar list of the smaller hospitals is to follow later.

The Minimum Standard, in accordance with this plan, was then defined. But this Standard, as just explained, has been in process of coming gradually to light. It grew out of straight thinking of the clearest minds in medical and hospital work on this continent. It is practicable, workable, and constructive. It costs effort rather than money. It safeguards the care of every patient admitted to the hospital by insistence upon competence on the part of the doctor, by thorough study and diagnoses in writing for each case, and by a checking up, at least once each month, of the clinical service of the

hospital. It fixes responsibility throughout the hospital. It calls for the "production sheets" of the hospital. It encourages and even compels research. It defines the minimum service to the patient which, beyond all debate, is considered essential.

Above all, the Minimum Standard is designed to bring a sense of responsibility to those who have to do with a hospital, that each patient admitted receives care scientifically sound. It is on this basis that the hospital may seek the confidence, good will, and support of its community; and it is through progress in this line that the medical profession may most swiftly advance to its rightful position in society.

The Minimum Standard as adopted follows:

THE MINIMUM STANDARD

1. That physicians and surgeons privileged to practice in the hospital be organized as a definite group or staff. Such organization has nothing to do with the question as to whether the hospital is "open" or "closed;" nor need it affect the various existing types of staff organization. The word *staff* is here defined as the group of doctors who practice in the hospital inclusive of all groups such as the "regular staff," the "visiting staff," and the "associate staff."

2. That membership upon the staff be restricted to physicians and surgeons who are (a) competent in their respective fields, and (b) worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees, under any guise whatever, be prohibited.

3. That the staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital; that these rules, regulations, and policies specifically provide: (a) That staff meetings be held at least once each month. (In large hospitals the departments may choose to meet separately.) (b) That the staff review and analyze at regular intervals the clinical experience of the staff in the various departments of the hospital, such as medicine, surgery, and obstetrics; the clinical records of patients, free and pay, to be the basis for such review and analyses.

4. That accurate and complete case records be written for all patients and filed in an accessible manner in the hospital, a complete case record being one, except in an emergency, which includes the personal history; the physical examination with clinical, pathological, and X-Ray findings when indicated; the working diagnosis, the treatment, medical and surgical; the medical progress; the condition on discharge, with final diagnosis; and, in case of death, the autopsy findings when available.

5. That clinical laboratory facilities be available for the study, diagnoses, and treatment of patients, these facilities to include at least chemical, bacteriological, serological, histological, radiographic, and fluoroscopic service in charge of trained technicians.

AS MEASURED BY MINIMUM STANDARD

During the years 1918 and 1919 visitors from the College, in accordance with the foregoing program, visited the general hospitals of 100 or more beds in the United States and Canada. This list includes 671 institutions, the names and locations of which are given in the following pages.

The following table indicates in condensed form the findings of the survey in the hospitals of 100 or more beds. In this table 671 hospitals are considered. Of this group 198 hospitals meet today the Minimum Standard. Many of these hospitals have been visited twice during the last two years, and in such cases the second report was utilized in the table. In many instances, also, the hospitals pledged themselves to fulfill the Minimum Standard at the earliest practicable date and later made a signed report of the extent of their success. The reports of the hospitals received in this way are also embodied in the table.

STAFF MEETINGS, CASE RECORDS, AND CLINICAL LABORATORIES IN GENERAL HOSPITALS OF 100 OR MORE BEDS

TABLE 1

1. IN UNITED STATES

Groups by No. of beds	No. hospitals in each group	Staff meetings each month	CASE RECORDS							Clinical Laboratories		No. hospitals meeting Min. Stand.*
			Personal history	Phys. Exam.	Working Diag.	Lab. Findings	Treatment or Operation	Progress Notes	Final Diag.	Path.	X-Ray	
100–149	282	91	131	117	112	181	178	112	194	170	174	66
150–199	133	49	67	56	54	95	93	56	97	96	95	37
200–249	65	27	30	31	27	40	40	27	40	40	40	22
250–299	57	33	32	31	28	42	41	28	44	44	42	24
300–349	24	13	13	12	12	18	18	14	20	21	20	8
350–399	11	6	6	6	5	6	6	5	6	6	6	3
400 or more	45	34	39	39	35	41	41	37	41	41	41	30
Totals	617	253	318	292	273	423	417	279	442	418	418	190

2. IN DOMINION OF CANADA

100–149	26	3	4	7	4	6	6	5	7	8	8	2
150–199	7	1	2	2	1	2	2	0	2	3	3	0
200–249	6	1	2	2	2	2	3	2	5	3	3	1
250–299	3	1	2	2	1	3	3	1	3	3	3	1
300–349	2	1	0	1	0	1	1	0	1	1	1	0
350–399	5	1	2	2	1	2	2	1	2	2	2	1
400 or more	5	3	3	3	3	4	4	3	4	4	4	3
Totals	54	11	15	19	12	20	21	12	24	24	24	8

*Number of hospitals in this column is reduced by failure in some instances to take action against division of fees.

PRACTICAL APPLICATION OF MINIMUM STANDARD

THE practical application of the Minimum Standard to the hospital and the meaning of this Standard, when in effective operation, to the community, are here considered.

The primary purpose of nearly all hospitals is the care of the sick or injured. This means that, as a matter of policy, the hospital seeks to render to each patient admitted the most efficient care known to the staff of the hospital. Hospitals and doctors accept this interpretation; otherwise the hospital would be merely a boarding-house for the sick or injured. Further, the trustees of the hospital, having accepted this policy, are responsible for the administration of the policy; and the people of the community have a right not only to assurance that the policy is carried out, but also to the facts upon which such assurance is based. It is only upon such a relationship of mutual confidence that the hospital may reasonably ask the good will and support of the community. Again, upon such a relationship rests the ultimate success of the hospital. The Minimum Standard is designed to foster just this fundamental relationship.

If the board of trustees is responsible that every patient, free or pay, in the hospital receives the best care known to the staff, then the board must at frequent intervals be in possession of the facts as to the care received by the patients in the hospital. The board must know, for example, if any unnecessary surgical operations are performed in the hospital; or if incompetent surgical operations are performed; or if lax, lazy, or incomplete diagnoses are made. If infections occur, the board must know, as nearly as may be, the cause of the infection, and it must know that every reasonable effort is made to remedy the cause. If the time of patients is wasted between their admission to the hospital and the proper study, diagnoses, and treatment of their illness, again the board must know the

facts and take action promptly to prevent further waste of this kind. Too frequently hospital trustees consider that their duties end with the management of the financial affairs of the hospital.

Now let us suppose that in a given city the leading hospital has "put on a campaign" to raise $100,000, and that the Chamber of Commerce, desiring to help the hospital, sends its representative to the trustees to ask whether or not the service at the hospital is what it should be. In other words, the Chamber of Commerce wants facts; it wants the "production sheets" of the cure and relief of illness.

What can the trustees answer? If the hospital is one which meets the Minimum Standard, the trustees are in position to say: "We have the facts as to the clinical successes and failures in the hospital. We give you these facts and rest our claim for support on them."

But if the hospital is one which does not meet the Minimum Standard, the trustees will probably reply: "We hope that all of our patients receive the right sort of care. We believe that they do. But we really know very little about the matter." This answer is sentimental rather than businesslike and will seldom win to-day the confidence of an intelligent community.

In case of the latter reply the Chamber of Commerce, and in fact the entire community, will do well to withhold support until the hospital produces evidence that it is worth while. Among the 671 general hospitals of 100 or more beds in the United States and Canada, about 468 of them cannot present at this time even a fairly complete analysis of their clinical work.

Let us suppose now that the trustees of one of these 468 hospitals decide that they will seek in a businesslike way the confidence of their community. What is their procedure?

Can the trustees "inspect" the hospital and through this means make a report concerning the clinical work in the hospital? The answer is no.

What the trustees can do is to call the doctors together who practice in the hospital and put the matter squarely up to them. After a statement of their own responsibility in the matter, the trustees can say: "We want you to organize as a group or staff and to create among yourselves a group-consciousness. *Minimum Standard, 1.* You are the experts. We ask that you draw up rules and regulations which if wisely administered will, in your judgment, provide for each patient in the hospital the highest service which is in your power to give. *Minimum Standard, 3.* We ask, further, that you meet as a staff at least once each month and that at these meetings you analyze your work in the hospital; that you find your mistakes or failures and, in so far as you can, prevent recurrence of the same mistakes or failures. *Minimum Standard, 3, (a) and (b).* We ask your co-operation, your guidance, and your confidence; we ask for the facts from time to time with regard to the clinical service in the hospital. In turn, we pledge our support."

The College in its work among hospitals has not found a single group of doctors practicing in a hospital who would not respond gladly to such a request from the governing board of the hospital. Here and there certain "obstacles" to the plan are raised. The chief of these is that the doctors are too busy to hold regular meetings and analyze their work. But in answer let us ask: Is any doctor too busy to give his patients the best service in his power?

After the staff has organized and after it has agreed upon rules and regulations governing the professional work in the hospital, and after these have been approved by the trustees, then it becomes the obligation of the trustees, through the superintendent of the hospital, to administer or to carry out the rules and regulations. It is essential that a spirit of co-operation exist between the superintendent and the staff in the administration.

ANALYSIS OF CLINICAL RECORDS

In order to make more clear what is meant by an analysis of the clinical service of a hospital, let us consider the following two series of 100 operations for chronic appendicitis, both of which are fairly typical of what happens to-day in hospitals.

	Hospital No. 1	Hospital No. 2
Complete physical examination, including blood count	100	14
Number of consultations held	41	2
Working diagnoses recorded in advance of operation	100	None
Progress notes recorded by doctor	100	None
Incorrect diagnosis	1	14
Infections following operation	3	12
Number patients relieved	94	77
Number patients died	3	9

The analysis of the cases treated in hospital No. 1 shows that a complete physical examination was made and recorded for each patient; that in order to clear away doubt as to the diagnoses, consultations were held in 41 cases; that the working diagnoses in each case were, then, in fairness to the patients, recorded in the permanent records of the hospital; that, after the operations, the physicians or surgeons in charge of each case made or signed daily a statement of the progress of the patient; that infections developed in 3 cases; that 4 incorrect diagnoses were made; that the number of patients apparently relieved of their illness was 94; and that 2 of the patients died following operation. This record is a credit to the staff of the hospital.

The corresponding data are now given for a similar series of cases in hospital No. 2. The data as here presented could not occur in a hospital which meets the Minimum Standard. In a hospital which meets the Minimum Standard, for example, it is not possible that any patient, except in an emergency, will go to operation in advance of a complete physical examination. But in hospital No. 2 eighty-six of the patients were operated upon without a complete physical examination. They were operated upon, it seems, after guess-diagnoses rather than after scientific diagnoses with consultations when indicated.

Considering the record of hospital No. 2, is there anything unreasonable in asking that the staff meet at least once each month, that it analyze the facts of its clinical work, that it determine, as nearly as may be, the causes of its failures; and that, demanding the support of the trustees, it endeavor to remove these causes? For example, 12 of the cases developed infection. Whose cases were these? What is the nature of the infection as indicated by laboratory analysis? Were the cases operated in rooms where pus cases had also recently been operated upon? Is the sterilization in connection with the operating room effective? When was it last tested and how? What technique is carried out in connection with surgical operations? And again, what were the reasons for the incorrect diagnoses? Do they indicate a lack of study, undue haste, or a failure to make full use of the laboratory facilities?

If the staff of hospital No. 2 would in dead earnest ask such questions as these each month, the percentage of infections would undoubtedly decrease. If the staff-review were really penetrating, the percentage of deaths would undoubtedly decrease. Matters, too, of incompetence, when the facts indicated incompetence, would be dealt with in no uncertain manner. The staff would become restricted. *Minimum Standard, 2.* The doctor scarcely exists who, if incompetent and if his incompetence is brought to light at frequent intervals, will not either endeavor promptly to perfect his training or retire from membership on the staff. The same principle is true with regard to character and professional ethics. Can any staff rest content with less than its maximum effort at all times to perfect the service of its hospital?

But the division of surgery, or the surgical cases, should not alone be analyzed by the staff. The clinical records of non-surgical cases merit quite as much attention. The study, diagnoses, treatments, and final results in pneumonia cases, cases of malnutrition, etc., should be reviewed. The services of the obstetrical department and of the children's department should, in the same way, be included.

In making analyses of clinical work, the confidential character of no record should be violated. The data for consideration of the

staff may be taken from summary cards from which the names of patients are omitted. See Bulletin, Vol. IV, No. 1.

Various hospital staffs at this time are in process of finding out for themselves the most effective means of analyzing their clinical records. The data as indicated on page 20 are found by a number of hospitals to be of stimulating value when presented to the staffs. Copies of these data are placed in the hands of each member of the staff; point by point the data are reviewed and the responsibility for the character of the data is shared by each staff member.

In order to compile the data called for on the sheet, it is suggested that a daily review be made of the records of patients discharged. This review will include information under each of the headings of the sheet. When a daily record is kept in this fashion the summary for the month is merely a matter of arithmetic.

From time to time exhibits are made showing these data comparatively through a series of months. In addition to these data some definite report of the laboratory service of the hospital is helpful. This report should show the extent to which the laboratory is used; and in this connection questions as to the adequacy and competence of the laboratory service should be raised by the staff. The staff should especially recognize good work on the part of the pathologist. All gross material removed at operations should go to the pathologist for report; and the case record of each death in the hospital together with the autopsy record when available should be presented as a routine at the next succeeding staff meeting.

Explanation of the practical application of the Minimum Standard which grew out of the experience of the Staff at St. Vincent's Hospital, Los Angeles, and at The Woman's Hospital, New York, are given in this pamphlet. In this connection the Staff rules and regulations as given in the appendix may also be helpful.

THE DIVISION OF FEES

In connection, further, with restricting the privilege of practice in hospitals, emphasis is placed upon the division of fees, or fee-splitting. *Minimum Standard, 2.* Fee-splitting is the buying and selling of patients. The practice exists in various forms, but the most usual form is as follows: A general practitioner makes a diagnosis in which surgical interference is indicated. He then refers the patient to a surgeon for operation. The surgeon operates, collects a fee, and sends to the physician one-third or one-half of the fee, this last transaction being unknown to the patient. Sometimes the physician collects the fee "for the surgeon" and retains his percentage as agreed with the surgeon.

Sometimes the fee is divided with the explanation to the patient that the physician "assists the surgeons" or gives the anesthetic. In many such instances the explanation is a subterfuge for fee-splitting. A competent surgeon usually has a regular assistant and an anesthetist with whom he is accustomed to work and is more able in this way to do good work than if he permits each referring doctor to assist him.

Undoubtedly the physician should be paid for the study and diagnosis of a surgical case. But he should be paid directly for this service by the patient. In the same way the surgeon should be paid directly by the patient. The surgeon can frequently be of service to the physician and to the patient by explaining to the patient the value of the study and diagnosis made by the physician. But the accounts of the physician and of the surgeon should not be confused or rendered to the patient as a single statement.

The evils of fee-splitting are, first, that it makes for incompetent surgery. The surgeon who is party to the practice gets his cases usually not upon the basis of merit, but upon the basis of the percentage of fees collected that he will give to the practitioners. The more incompetent he is, as a rule, the larger per cent of the fees he gives to his co-fee-splitters.

Second, fee-splitting makes for unnecessary surgical operations. Under the fee-splitting system surgery becomes a commercial enterprise and not a professional service. Both the physician and the surgeon tend to make surgical diagnoses without adequate study, and the result is unnecessary surgery. Much

of the unnecessary surgery of our present day is due directly to fee-splitting.

Third, fee-splitting, by introducing dishonesty into medical practice, lowers the entire medical profession in the estimate of the public. The fee-splitter, for example, says to his patient that he refers him to a most competent surgeon, when he knows well enough that if he, the physician, were to be operated upon, he would select another surgeon. Further, the fee-splitter usually poses before his patient as having received little or no fee for his services when, as a matter of fact, he has received a large fee indirectly from the patient. He holds such a fee really as a theft.

Fee-splitting is now prohibited by law in the following states: Minnesota, Wisconsin, Nebraska, West Virginia, Alabama, Ohio, Kansas, Iowa, Tennessee, Colorado, Michigan, and Georgia.

The great majority of physicians and surgeons are most sincerely eager to put an end to all fee-splitting. They ask the hospital trustees to help them in this matter by excluding fee-splitters from the privileges of practice in hospitals.

The College asks each hospital to make clear to its staff and to its community a definite policy against fee-splitting. Where no action has been placed on record in this matter, the College suggests that the governing boards of hospitals pass the following resolutions:

> *Be it resolved:* That the practice of the division of fees is inconsistent with the policy of ..... Hospital and that physicians and surgeons who divide fees are not permitted to practice in the Hospital; and further,
>
> *Be it resolved:* That a copy of these resolutions be sent to each physician and surgeon now practicing in the Hospital.

CHRONOLOGICAL STATEMENT OF HOSPITAL STANDARDIZATION

May 5, 1913 — American College of Surgeons organized in Washington, D. C. Betterment of service in hospitals among objects of College.

June 22, 1914 — Plan to raise permanent endowment fund for the College approved by the Fellows, the income from this fund to be used in carrying out purposes of the College.

December 1, 1915 — Endowment fund of $526,000 subscribed by Fellows of the College.

January 27, 1916 — Gift of $30,000 from the Carnegie Corporation, New York, to be used for hospital standardization.

September 27, 1916 — American Hospital Association in session at Philadelphia invited to co-operate with College in hospital standardization. Association appointed a committee to co-operate with the College as invited.

October 27, 1916 — Plan to organize State and Provincial Committees on Standards to guide and aid in the program of hospital standardization voted by Fellows.

November 30, 1916 — Members of State and Provincial Committees on Standards elected by ballot.

January 11, 1917 — Plan of hospital standardization, in relation to Catholic hospitals, approved by His Eminence James Cardinal Gibbons at Baltimore.

October 19, 20, 1917 — Meeting of the State Committees on Standards in Chicago. Throughout two days the following subjects were considered:

1. The number, distribution, valuation, and general classification of hospitals; and the relation of hospitals to the general public.
2. What the profession of medicine wants in hospitals.
3. How to bring about desired conditions in hospitals.

About three hundred members of State Committees on Standards and sixty leading hospital superintendents present at Conference. The papers presented, together with summary of discussion, published as Bulletin, Vol. III, No. 1.

October 25, 1917 — General Hospital Committee of twenty-one appointed by Regents to outline questionnaire and consider the Minimum Standard as advised by Conference, October 20.

December 8, 9, 1917 — General Hospital Committee met in Washington with Regents of College. An initial questionnaire formulated. Details of Minimum Standard considered with reference to the following: a system of financial accounting and of making annual reports; uniform nomenclature; the training of superintendents; the training of internes; the training of nurses; hospital organization; staff rules and regulations; the function of staff meetings; case records and follow-up of records; post mortem examinations; clinical laboratories; the out-patient department; the economic relation of the hospital to its community; ethics of medical practice in the hospital; education of patients and of the community in matters of health, hygiene, and sanitation; the responsibility of the hospital to the patient; encouragement of medical research and of medical education; the hospital library; continuity of service to patients by doctors; dietetics; the testing of materials and supplies before purchase; the receiving and checking-out of materials and supplies through the hospital storeroom; model plans for new buildings and additions; and means of increasing the financial support of the hospital.

December 19, 1917 — Meeting of Governors of College in Washington. Program of hospital standardization approved. Consensus of opinion that the work should be carried out through personal inspections by Staff members of the College.

February 15, 1918 — General hospitals of 25 or more beds invited to co-operate with College in hospital program. Invitation and questionnaire sent to 2,711 hospitals. Copy of invitation and of questionnaire sent also to Fellows for their information.

March 1, 1918 — Minimum Standard and plan of hospital standardization sent to hospitals and to Fellows. Bulletin, Vol. III, No. 3.

April 1, 1918 — Work of personal investigation of hospitals begun. Investigations limited to general hospitals of 100 or more beds. Visitors or inspectors employed to explain to hospital trustees, superintendents, and staffs the hospital program of College and to make specific reports of hospital conditions as indicated by Minimum Standard. Report forms designed for this purpose. Co-operation of Fellows with visitors. An illustration of a visitor's report follows:

HOSPITAL STANDARDIZATION REPORT

Name of Hospital: Blodgett Memorial Hospital, Grand Rapids, Michigan.
Date of Visit: March 15, 1919. *Visitor:* Anna C. Phillips.
Type: General. *No. of beds:* 125.
No. of Internes: None; usually 3. *No. in nurses' training school:* 71.
Staff Organization: Open Hospital without definitely organized Staff; no review or analysis of professional work; division of fees not permitted.
Case Records: Current records consisted only of nurses' notes, anesthetic record in surgical cases, and final diagnoses. Occasional physical examinations and laboratory reports were found among the filed records. Records filed on shelves in general office by clerk.
Clinical Laboratories: Pathological: accessible, light, well equipped; no pathologist, no technician; facilities used occasionally by attending doctors. X-Ray: accessible, well planned, completely equipped; no technician; facilities used only occasionally by attending doctors.
Notes: Conditions as to Staff organization, case records, and laboratories discussed with Executive Committee of Board and with Superintendent; work of College explained. Effort being made to secure laboratory technician. Board responsive and much interested. Glad to co-operate. Ideals of all connected with Hospital excellent.

Summary of Final Action Reported August 12, 1919

Staff Organization: Staff reorganized, meets bi-weekly to consider the character of the clinical service and other matters relative to the care of patients, such as laboratory service, etc. In the reorganization there are two groups:

1. Executive Group: Experts in special fields of work.
2. Associate Group: General practitioners.

In accepting appointment to Staff, physicians and surgeons are required to agree to the following:

> "To abide by the rules and regulations of the Hospital, and to adhere at all times to the well recognized, lofty principles governing the reputable practice of medicine and surgery.
>
> "That as a principle I shall not engage in the division of fees under any guise whatever, nor knowingly permit any agent or associate of mine so to do.
>
> "To exercise to the best of my ability a constructive interest in the Hospital, and to co-operate in making it as potent a factor as possible in the preservation of public health in this community."

Case Records: A complete new record system instituted July 1, 1919. Complete case records including personal history, physical examination, working diagnosis, laboratory findings, treatment or operation, progress notes, and final diagnoses are kept for all classes of patients treated, free and pay.

Clinical Laboratories: The X-Ray department is in charge of a full time röentgenologist; the pathological laboratory is in charge of a full time technician; serological and histological work sent to outside laboratory.

June 20, 1918 — Meeting in Chicago of Catholic Hospital Association. The following resolutions were passed:

Be it resolved: That we, the Catholic Hospital Association of the United States and Canada, now assembled at Chicago in our third annual convention, approve of the work being done by the American College of Surgeons for the standardization of hospitals, and assure the College of our fullest co-operation in its endeavor for the betterment of hospitals and the resultant increased welfare of mankind.

Be it resolved: That we, the members of the Catholic Hospital Association, pledge ourselves to organize controlled staffs in our hospitals; to establish or continue an adequate system of case records, with a Sister in charge having full authority to demand the careful co-operation of doctors, internes, and nurses; to secure from our superiors, staffs, or friends, funds properly to equip all necessary laboratories and to bring about as soon as possible the scientific training of our Sisters and technicians of all kinds, anesthetists, dieticians, record-keepers, and social service experts.

We further pledge ourselves to urge all surgeons who are privileged to practice in the hospitals of the Association, and who are not at this time Fellows in the American College of Surgeons, to qualify as soon as they are able for Fellowship in the College.

We further wish to express our desire that all doctors who practice in our hospitals be or become, as soon as practicable, members in good standing of their respective county medical societies and contribute their share to the active medical life of said societies.

We further wish to express our conviction that the secret division of fees, as condemned by the American College of Surgeons, is an unethical and nefarious practice which we pledge ourselves to keep out or root out of our hospitals.

June 21, 1918 — Meeting in Chicago of Bishops and Archbishops(or their representatives) of the Catholic Church in the United States and Canada to consider the program of the College in relation to Catholic hospitals. Program of the College approved.

September, 1918 — Meeting in Hamilton, Ontario, of the combined Surgical Section of the Ontario Medical Association and the Canadian Medical Association. The following resolution was passed:

Be it resolved: That we, the Surgical Section of the combined meeting of the Ontario Medical Association and the Canadian Medical Association, desire to go on record as approving the efforts being made by the American College of Surgeons to improve the status of surgical practice in our hospitals . . . that the right to attempt major surgery should be restricted to those who are recognized as having scientific training, experience, sound judgment, and honesty of purpose . . . that examinations for diagnosis and for treatment should be made more closely associated with clinical laboratories than they are at present. . . .

October 23, 1918 — Hospital conference arranged to be held in New York in connection with the Clinical Congress of the College. Fellows of the College and hospital superintendents of the United States and Canada invited. Meeting cancelled because of influenza.

January 15, 1919 — Bulletin, Vol. IV, No. 1, published. Detailed explanation of the Minimum Standard with special reference to the meaning and use of case records. 27,000 copies distributed.

January 15, 1919 — Bulletin, Vol. IV, No. 2, published. Forms suggested for the keeping of case records in a simple, convenient, and adequate manner. 27,000 copies distributed.

February 1, 1919, to May 15, 1919 — Hospital conferences, many of them including one or more states or provinces, arranged throughout western half of United States and Canada. Hospital standardization presented to hospital trustees, superintendents, medical profession, nurses, and to general public. These conferences usually included special meetings with county medical societies, Chambers of Commerce, business men's associations, and Canadian clubs. The conferences were designed to supplement the work of the hospital visitors on the Staff of the College. Meetings were held at St. Louis, Memphis, New Orleans, Fort Worth, Denver, Ogden, Salt Lake, San Diego, Los Angeles, San Francisco, Portland, Tacoma, Seattle, Victoria, Vancouver, Calgary, Edmonton, Regina, Winnipeg, Minneapolis.

The following program is typical of these occasions:

HOSPITAL STANDARDIZATION CONFERENCE
PORTLAND AND VICINITY

April 11, 1919

LUNCHEON, CHAMBER OF COMMERCE, 12:15 P. M.
A. L. MILLS, Presiding

The Hospital and its Community . . . . . JOHN G. BOWMAN
Director of College, Chicago
and
CHARLES B. MOULINIER, S. J.
President Catholic Hospital Association, Milwaukee

AFTERNOON SESSION, 2:00 O'CLOCK
LINCOLN HIGH SCHOOL

The Occasion for the Conference . . . . . DR. KENNETH A. J. MACKENZIE
Chairman State Committee on Standards

What is Hospital Standardization? . . . . . JOHN G. BOWMAN
(Clinical Laboratories, Case Records, Staff Organization)

Discussion:

(a) Clinical Laboratories . . . . . DR. A. E. MACKAY
MAJOR R. L. BENSON

(b) Case Records . . . . . MAJOR RALPH C. MATSON
MAJOR WM. S. KNOX

(c) Staff Organization . . . . . DR. S. E. JOSEPHI
DR. E. F. TUCKER

Summary . . . . . CHARLES B. MOULINIER, S. J.

EVENING SESSION, 8:00 O'CLOCK
LINCOLN HIGH SCHOOL

Hospital Progress; The Citizen's Part . . . . . A. L. MILLS
What the Medical Profession Wants in Hospitals . . . . . JOHN G. BOWMAN
Team Work for Success . . . . . CHARLES B. MOULINIER, S. J.
Summary of Conference . . . . . DR. KENNETH A. J. MACKENZIE

September 11, 1919 — American Conference on Hospital Service organized at Cincinnati. Chairmanship of Committee in charge of standardization of hospital service voted to American College of Surgeons.

October 24, 1919 — Report to Fellows of the College in connection with the ninth meeting of Clinical Congress of the College, New York, concerning hospital standardization as applied to general hospitals of 100 or more beds. The practical administration of the Minimum Standard presented.

APPENDICES

STAFF RULES AND REGULATIONS

I. ELLIS HOSPITAL, SCHENECTADY

The physicians and surgeons practicing in the Ellis Hospital, Schenectady, New York, having organized as a Staff with regular meetings, adopted the following rules:

1. The Ellis Hospital shall keep in a systematic manner case records of all patients treated in the Hospital together with a convenient summary of each case; and these records shall be utilized in analyses to ascertain the efficiency of the medical and surgical work done in the Hospital.

2. The case records of the Hospital shall contain the following data for each patient treated: Identification of the patient by name or number; name of physician or surgeon responsible for the case; personal history of patient relevant to complaint; diagnosis on which treatment was based; laboratory and physical findings; important points of operation or of treatment; post-operative diagnosis; complications of convalescence; follow-up records; and, in case of death, autopsy findings when available.

3. It shall be the duty of the historian to record the necessary data on forms prescribed by the History Committee of the Staff.

4. The data may be recorded by the attending physician or surgeon, or by an interne or by the historian, but the historian shall be responsible that a history be written in each case. Refusal or neglect on the part of an attending man to give the necessary aid to the historian in procuring the data shall terminate his privilege of treating cases in the Hospital.

5. It shall also be the duty of the historian to make out a summary card for each patient together with the follow-up record. It shall be her duty to make statistical compilations of the result obtained for analysis and review by the Staff of the Hospital.

6. Medical histories must be taken and physical examinations made not later than the first twenty-four (24) hours after the patient is admitted to the Hospital.

7. In surgical cases the essential history pertaining to the condition for which the patient is to be operated upon, together with the record of the physical examination, must be furnished to the Hospital before the patient is operated upon, except that in emergency cases this history may be dictated by the surgeon before or during the operation. In non-emergency operative cases the history and record of the physical examination shall be delivered to the Hospital by the surgeon or ample time shall be allowed for taking the history of surgical patients after the patient reaches the Hospital.

8. In all surgical cases the surgeon shall, previous to operation, record the diagnosis on which his treatment is based. This diagnosis shall be posted on the board where operations are listed.

9. During, or at the close of each operation, a description of the pathological findings and of the operation shall be recorded together with a diagnosis based on the gross pathology. This shall be dictated by the surgeon himself.

II. ST. MARY'S HOSPITAL, CHICAGO

1. The Staff and Visiting Staff shall meet in joint session at least once each month.

2. The meetings shall be held at the Hospital at six o'clock in the evening of a fixed day each month.

3. The general order of business shall be: business meeting from six to seven o'clock;

dinner from seven to eight o'clock; scientific meeting from eight to nine o'clock.

4. The cost of dinner to Staff members shall be $1.00. If a Staff member is not present the $1.00 shall be charged to his account notwithstanding, and the same credited to the Library Fund of the Hospital.

5. The business meeting shall deal with problems and analyses which relate to the efficiency of the Hospital.

6. All subjects, except such as demand immediate attention, shall be proposed at one meeting and taken up at the following meeting.

7. A box for questions concerning the welfare of the Hospital shall be provided and questions proposed in this manner shall be made part of the business session.

8. At each scientific meeting one of the internes shall read a carefully prepared history of some case of special interest which shall be discussed first by the other internes and then by the members of the Staff.

9. At each scientific meeting, also, a Staff member shall read a scientific paper. This paper shall then be open for discussion, the policy being that the author shall later revise the paper and present it at some medical or surgical society.

10. A register of attendance shall be kept of each meeting.

III. EVANSTON HOSPITAL, EVANSTON

Recent interest in the effectiveness of Staff meetings at the Evanston Hospital, Evanston, Illinois, is expressed by a series of resolutions adopted by the Staff. These resolutions follow:

1. That the system of records of the Hospital be expanded as suggested by the Committee on Standardization of Hospitals of the American College of Surgeons, and that a standing Committee on Records of three members be appointed from the Staff to whom all matters pertaining to the records of the patients be referred—the Committee to work in conjunction with a historian of the Hospital and to have jurisdiction over the records of all patients cared for by any physician whether on the Staff or not. This Committee shall co-operate with the Executive Committee in the selection of the historian, on request. It is suggested that the duties of this historian include the following:

   a. A general supervision of the records and methods of filing the same as found most convenient for all concerned.
   b. To see that no history is filed without all parts being completed.
   c. To keep the proper case indexes and cross systems of reference.
   d. To make such statistical studies as shall be asked of the Hospital. The assistance of the Staff Committee may be asked for.
   e. To carry out a follow-up system in so far as possible.
   f. To be responsible that the operative sheet is properly filled out at the time of operation. An operating room assistant may do the actual recording under the authority of the historian.
   g. To report to the Record Committee of the Staff any physicians who are persistently negligent about matters pertaining to the records.

2. That recommendations for new members of the Senior Staff shall be made from those physicians who are limiting their work to definite lines, and it shall be the policy of the present members to limit their work as rapidly as possible to the type of work of the departments to which they are assigned.

3. Each member of the Junior Staff shall have as his ultimate aim the limitation of his practice to the type of work of the department to which he is assigned, and shall under these conditions be eligible to a position on the Senior Staff at such time as there shall be a vacancy on that Staff—seniority of service on the Junior Staff having a large influence on the selection, but not being the sole determining factor in the selection.

4. Each senior and junior member of the Staff shall attend a national or special society meeting at least once in three years.

5. Each senior member shall devote a total of at least one month in twenty-four

to bona-fide attendance on some recognized clinics, devoting a large part of his time to his chosen subject.

6. It is *suggested* that each junior member follow the same plan, devoting as much time as possible to subjects allied to his chosen future work.

7. In January of each year the secretary of the Staff shall obtain from each member of the Staff, both Senior and Junior, information concerning his attendance on meetings and clinics, to be presented to the president of the Board.

8. Any member who is persistently negligent in matters pertaining to records of his patients shall be reported by the historian to the Committee on Records of the Staff, which may recommend such action as it sees fit.

9. That any member found guilty of fee-splitting in the accepted meaning of that term be dismissed from the Staff.

EXAMPLES OF THE PRACTICAL APPLICATION OF MINIMUM STANDARD

I. ST. VINCENT'S HOSPITAL, LOS ANGELES

Dr. Edward T. Dillon, Surgeon-in-Chief at St. Vincent's Hospital, Los Angeles, thus described what standardization means to his Hospital:

"For many years St. Vincent's Hospital was conducted as a general open-staff hospital. It assumed no direction in methods of examination or treatment employed. It executed orders only of general care and nursing.

"However, the idea of bettering this situation grew and developed. Then, to accomplish a reform, it became necessary to subordinate the individual, to overturn a routine of years, to co-ordinate the efforts of the Hospital and of the physician, to eliminate those of the profession who failed to meet the demands and responsibilities of a more complex organization, to do the best for humanity regardless of the personal equation.

"Briefly, we required these things: Signed records, including the personal history, physical examination, routine blood and urine examinations, and recorded blood pressure in all cases before any treatment whatsoever is instituted. There are no exceptions to this rule. Clinical diagnosis must be supported by laboratory findings. Patients may not be taken to the operating room unless accompanied by these records together with a written pre-operative diagnosis. All tissue removed remains in the possession of the Hospital and, as a routine, is sent to the laboratory for analysis and report. All records, together with the summary, final result, and follow-up card remain in and are the property of the Hospital. Records are inspected, and there must be the proper co-ordination between recorded findings, diagnosis, and proposed treatment. This applies particularly to surgical cases. Post-operative complications, delayed or unsatisfactory results, are not considered a matter of individual responsibility. They are investigated by the authoritative co-operation of the Staff and the Hospital administration, and the cause determined if possible. Regular meetings of the Staff afford opportunity for discussion of problems of procedures connected with the Hospital.

"The Hospital does not now hesitate to refuse admission to such patients as have incompetent medical or surgical advisors. The question of their refusal or admission is no longer a personal or individual matter, but merely the meeting of certain well-founded regulations.

"These things have not been accomplished without friction and criticism. But we have zealously endeavored to establish the merit of what we stand for. Already, discontent with and antagonism to the new order have practically disappeared. The benefits derived from the adopted measures of standardization have come to all patrons of St. Vincent's Hospital both within and without the profession. The careless or indifferent practitioner has benefited by examples of conscientious work and its fruitfulness; the

incompetent practitioner has been excluded from the privileges of practice in the Hospital. Patients have shown their appreciation of this great work through an increased waiting list for entrance to the Hospital. The community at large has realized in a short space of time that the standardized hospital offers a superior service. Its appreciation has also been shown by the demand for a larger institution and by offers of financial assistance to carry the work still further."

II. THE WOMAN'S HOSPITAL, NEW YORK

Marked interest centered in the work at The Woman's Hospital, New York, as directed by Dr. George Gray Ward, Jr., with regard to Staff meetings. Dr. Ward said:

"A Staff conference is held once a week throughout nine months of the year which the entire Hospital Staff is always expected to attend. These conferences last about one hour and the medical public is welcome. The order of procedure is as follows:

"*Presentation by the pathologists* of the pathological material of interest which has been obtained during the week; gross and microscopical specimens together with brief talks on the pathology.

"*The casualties of the service* are next called for. Each attending surgeon must report any deaths, infections, or complications occurring during the week in patients under his care, and an endeavor is made to locate the cause. The details as shown by the case histories, and the testimony of those concerned are carefully analyzed in order that it may be determined, as far as possible, whether the fault lay with the doctor, the patient, the disease, or the hospital organization or equipment.

"*A report on the analysis* of the 'follow-up' clinic of one of the attending surgeons is next made. Each of the four attending surgeons has such a clinic once a week which he must attend in person, and once in four weeks these surgeons are required to make an analysis of the results of the cases they have seen since their previous report. This analysis must show the total number of cases seen in the clinic and the number of those which have previously been reported. The remainder which are to be reported are classified according to the results as successful, partially successful, and failures. The acid test for the determination of the result is whether the patient has been relieved of the symptoms for which she sought relief, and not whether the operative result is satisfactory to the surgeon. The successful cases are disregarded, while each partially successful case and failure must be analyzed in detail and the reasons given for the classification. A free discussion is encouraged in order that the operating surgeon may have every opportunity to defend his position. Cases that may have been previously reported as successful and which may later become partially successful or failures, must be subsequently reported with their revised classification.

"*A report of a few cases* of special interest is next made by some of the attending surgeons, in turn. Thus an opportunity is given to report on case histories or to present patients who have been treated with successful results. Frequently a case presenting difficulties in diagnosis or treatment is shown, and the advice of the conference is sought. Once each month the junior attending surgeons are required, in turn, to give a brief summary of the recent gynecological and obstetrical literature, or to give a report on any hospital or operative clinic they may visit. Problems relating to technique, operating rooms, sterilizing rooms, wards, etc., are brought forward for general discussion when necessary in order that various points of view may be obtained. A stenographer is present during the conferences and makes complete stenographic reports of the proceedings, which are kept on file in the office of the chief surgeon for further study."

MILITARY ANALYSES OF RECORDS

The general policy to review and analyze the clinical records of the U. S. Army Hospitals is made effective by the Surgeon General's Office. The extent to which clinical records of U. S. Army Hospitals are analyzed is indicated by the following extracts from orders issued by the Surgeon General to Army Hospitals, March 20, 1918:

1. It is directed that a monthly report of operations performed in your Hospital be submitted to this Office.

* * * * * *

3. This report will be accompanied by a supplemental report containing information on the following points, viz:

I. The total number of cases operated upon.

II. The total number of deaths in the surgical division:
   a. Unoperated.
   b. Operated.
   c. Autopsied.
   d. Detailed facts in connection with each death, including cause, primary and secondary.

NOTE: In case of appendicitis, give interval of time after onset of symptoms before entering Hospital and interim after entering Hospital before operation.

III. The number of clean wounds becoming infected:
   a. Date of operation.
   b. Names of operators and assistants in each infected case.
   c. Discuss cause known or suspected in any case.
   d. Give type of organism, if known.

Again the care with which the Surgeon General's Office checks up the medical and surgical service in Army Hospitals is illustrated by the following paragraph sent by the Surgeon General to the Chief of Surgery at one of the Army Hospitals:

"One death was said to be due to acute suppurative osteomyelitis of the left ischium and acute suppurative arthritis of the left hip. The patient was in the hospital four days suffering severe pain before he was operated at all. On the fifth day drainage was instituted. Two weeks later he was operated, and a third operation eleven days after the second operation. At this last sitting the sequestrum was removed and the hip was resected. Patient died the same day. The Division of Surgery should have a complete clinical and laboratory record transcribed in this case for review, as there surely must be some question raised as to why this case was not operated earlier, and also as to whether good judgment was used in making resection under the existing circumstances."

ANALYSIS OF HOSPITAL SERVICE

for month ending_____

DISCHARGED

Cured	
Improved	
Relieved	
Unimproved	
To return for secondary operation	
Admitted for diagnosis only	
Deaths within 48 hours	
Deaths institutional	
Released	
Labor	
Newborn	
Total discharged	

DIAGNOSES

Provisional and final agree	
Provisional and final disagree	
Discharged with additional diagnosis	
Discharged with no diagnosis made	
Labor	
Newborn	
Total discharged	

INFECTIONS

Institutional		On Admission	
Medical		Medical	
Surgical		Surgical	
Obstetrical		Obstetrical	
Total infections			

CONSULTATIONS

Asked and obtained	
Asked, not obtained	
Indicated, not asked	

DEATHS

Medical	
Surgical	
Obstetrical	
Newborn	
Stillborn	
Total deaths	

AUTOPSIES

Medical	
Surgical	
Obstetrical	
Newborn	
Stillborn	
Total autopsies	

CAUSES OF DEATH

Total deaths

UNIMPROVED

Total unimproved

GENERAL HOSPITALS OF 25 OR MORE BEDS

MORBIDITY BY STATES

SUMMARY OF TABLES (3) AND (4)

TABLE 2

STATES	Population 1930 Census Estimate	No. Hospitals	Total No. of Beds	No. Pop. to One Bed	No. Patients (Per Yr.	Av. No. Patients Per Bed	% Pop. Treated Per Yr.	Total No. Days' Treatment	Av. No. of Days' Treat.	Ratio Patients to Pop.
Alabama	2,395,270	30	1900	1261	30,814	16	1.29	693,467	23	1 to 78
Arizona	272,034	9	444	613	8,346	19	3.07	162,040	19	33
Arkansas	1,792,965	25	1516	1183	25,023	17	1.40	553,386	22	72
California	3,119,412	135	11468	272	200,734	18	6.43	4,186,126	21	16
Colorado	1,014,581	34	2748	369	42,506	15	4.02	1,002,912	24	24
Connecticut	1,286,268	35	3584	359	63,865	18	4.97	1,308,139	20	20
Delaware	216,941	6	574	378	9,340	16	4.31	209,554	22	23
Dist. of Col.	374,584	15	2284	164	35,903	16	9.58	833,496	23	10
Florida	938,877	26	1229	764	20,528	17	2.19	448,003	22	46
Georgia	2,935,617	34	2577	1139	50,296	20	1.71	940,411	19	58
Idaho	461,766	17	790	585	12,837	16	2.78	288,392	22	36
Illinois	6,317,734	176	17404	363	317,805	18	5.03	6,350,978	20	20
Indiana	2,854,167	66	5049	565	84,589	17	2.96	1,843,137	22	34
Iowa	2,224,771	79	5440	408	88,994	16	3.98	1,985,065	22	25
Kansas	1,874,195	53	2828	663	45,221	16	2.41	1,032,159	23	41
Kentucky	2,408,547	33	2765	871	39,453	14	1.64	1,009,049	26	61
Louisiana	1,884,778	21	2807	671	48,044	17	2.55	1,024,677	21	39
Maine	782,191	23	1315	595	19,640	15	2.51	480,002	24	40
Maryland	1,384,539	42	4363	317	65,475	15	4.73	1,592,445	24	21
Massachusetts	3,832,790	112	10321	371	179,647	17	4.69	3,767,348	21	21
Michigan	3,133,678	79	6036	519	105,335	17	3.36	2,203,196	21	30
Minnesota	2,345,287	85	6805	345	111,821	16	4.77	2,483,571	22	21
Mississippi	2,001,466	20	1050	1906	17,311	16	.86	383,385	22	116
Missouri	3,448,498	72	7089	487	116,406	16	3.38	2,587,105	22	30
Montana	486,376	29	1833	265	36,675	20	7.54	669,060	18	13
Nebraska	1,296,877	38	2679	484	40,860	15	3.15	977,855	24	32
Nevada	114,742	5	210	546	3,060	15	2.67	76,653	25	37
New Hampshire	446,352	20	942	474	14,678	16	3.29	343,803	23	30
New Jersey	3,080,371	66	6960	443	120,373	17	3.91	2,540,167	21	26
New Mexico	437,015	6	279	1566	4,815	17	1.10	101,837	21	91
New York	10,646,989	262	31967	333	551,586	17	5.18	11,668,855	21	19
North Carolina	2,466,025	45	2305	1070	36,099	16	1.46	841,173	23	68
North Dakota	791,437	26	1371	577	24,258	18	3.07	509,282	21	33
Ohio	5,273,814	112	11132	474	179,424	16	3.40	4,142,472	23	29
Oklahoma	2,377,629	32	1450	1640	25,468	18	1.07	529,048	21	93
Oregon	888,243	31	1986	447	32,522	16	3.66	724,945	22	27
Pennsylvania	8,798,067	213	23656	372	388,736	16	4.42	8,634,597	22	23
Rhode Island	637,415	11	1144	557	18,854	16	2.96	417,608	22	34
South Carolina	1,660,934	26	1401	1186	22,042	16	1.33	511,341	23	75
South Dakota	735,434	23	1124	654	19,044	17	2.59	410,279	22	39
Tennessee	2,321,253	40	2836	818	49,242	17	2.12	1,035,180	21	47
Texas	4,601,279	75	5265	874	83,141	16	1.81	1,921,450	23	55
Utah	453,648	10	836	543	14,157	17	3.12	305,102	22	32
Vermont	366,192	12	614	596	10,087	16	2.75	224,087	22	36
Virginia	2,234,030	54	3276	682	56,933	17	2.55	1,195,646	21	39
Washington	1,660,578	59	4102	405	77,784	19	4.68	1,496,948	19	21
West Virginia	1,439,165	41	2530	569	40,972	16	2.85	923,551	23	35
Wisconsin	2,553,983	75	5192	492	87,031	17	3.41	1,895,348	22	29
Wyoming	190,380	9	453	420	7,033	16	3.69	165,276	24	27
Totals	105,259,184	2547	217,929	483	3,654,447	16.91	3.50	79,541,537	21.58	1 to 29

GENERAL HOSPITALS OF 25 TO 99 BEDS

MORBIDITY BY STATES

TABLE 3

STATES	Population 1918 Census Estimate	No. Hospitals	Total No. Beds	No. Population One Bed	No. Patients Per Yr.	Av. No. Patients Per Bed	% Pop. Treated Per Yr.	Total No. Days' Treatment	Av. No. Days' Treat.	Prop. Patients to Pop.
Alabama	2,395,270	24	982	2439	16,943	17	.71	358,344	21	1 to 141
Arizona	272,034	8	319	853	5,502	17	2.02	116,422	21	49
Arkansas	1,792,965	22	1066	1683	18,573	17	1.04	389,104	21	97
California	3,119,412	100	4550	686	78,977	17	2.53	1,660,886	21	39
Colorado	1,014,581	25	1103	920	18,653	17	1.84	402,532	22	54
Connecticut	1,286,268	23	1199	1073	20,387	17	1.59	437,769	21	63
Delaware	216,941	4	174	1247	2,811	16	1.30	63,500	23	77
Dist. of Col.	374,584	5	341	1098	5,884	17	1.57	124,447	21	64
Florida	938,877	24	1014	926	17,838	18	1.90	370,139	21	53
Georgia	2,935,617	26	1252	2345	22,232	18	.76	456,868	21	132
Idaho	461,766	16	675	684	11,181	17	2.42	246,429	22	41
Illinois	6,317,734	125	6379	990	110,535	17	1.75	2,327,867	21	57
Indiana	2,854,167	48	2129	1341	36,117	17	1.27	777,238	22	79
Iowa	2,224,771	68	3217	692	57,539	18	2.59	1,173,796	20	39
Kansas	1,874,195	49	2034	921	33,331	16	1.78	742,281	22	56
Kentucky	2,408,547	24	1090	2210	18,383	17	.76	397,808	22	131
Louisiana	1,884,778	15	603	3126	12,317	20	.65	220,105	18	153
Maine	782,191	18	682	1147	10,905	16	1.39	248,961	23	72
Maryland	1,384,539	29	1451	954	24,974	17	1.80	529,699	21	55
Massachusetts	3,832,790	83	4001	958	68,794	17	1.79	1,460,497	21	56
Michigan	3,133,678	64	2631	1191	49,153	19	1.57	960,450	20	64
Minnesota	2,345,287	67	2744	855	48,226	18	2.06	1,001,172	21	49
Mississippi	2,001,466	17	700	2859	12,057	17	.60	255,608	21	166
Missouri	3,448,498	47	2092	1648	34,955	17	1.01	763,417	22	99
Montana	486,376	24	1141	426	19,937	17	4.09	416,484	21	24
Nebraska	1,296,877	30	1376	942	23,115	17	1.78	502,289	22	56
Nevada	114,742	5	210	546	3,060	15	2.66	76,653	25	37
New Hampshire	446,352	19	827	540	13,106	16	2.93	301,831	23	34
New Jersey	3,080,371	38	1995	1544	35,968	18	1.17	727,992	20	86
New Mexico	437,015	6	279	1566	4,815	17	1.10	101,837	21	91
New York	10,646,989	175	9139	1165	163,282	18	1.53	3,335,851	20	65
North Carolina	2,466,025	41	1843	1338	28,732	16	1.17	672,616	23	86
North Dakota	791,437	24	1101	719	19,770	18	2.50	401,726	20	40
Ohio	5,273,814	77	3675	1435	65,257	18	1.24	1,341,031	21	81
Oklahoma	2,377,629	31	1320	1801	23,529	18	.99	481,639	20	101
Oregon	888,213	28	1236	719	20,968	17	2.36	451,231	22	42
Pennsylvania	8,798,067	141	7569	1162	123,300	16	1.40	2,763,153	22	71
Rhode Island	637,415	8	360	1771	6,545	18	1.03	131,424	20	97
South Carolina	1,660,934	22	838	1982	13,338	16	.80	305,840	23	125
South Dakota	735,434	22	1024	718	17,369	17	2.36	373,781	22	42
Tennessee	2,321,253	33	1538	1509	26,337	17	1.13	561,505	21	88
Texas	4,601,279	58	2410	1909	40,031	17	.87	879,481	22	115
Utah	453,648	7	310	1463	5,522	18	1.22	113,146	20	82
Vermont	366,192	11	484	757	7,854	16	2.14	176,636	22	47
Virginia	2,234,030	49	2286	977	39,717	17	1.78	834,454	21	56
Washington	1,660,578	49	2414	688	41,615	17	2.51	880,990	21	40
West Virginia	1,439,165	34	1543	933	25,614	17	1.78	563,252	22	56
Wisconsin	2,553,983	58	2746	930	48,963	18	1.92	1,002,273	20	52
Wyoming	190,380	9	453	420	7,033	16	3.69	165,276	24	27
Totals	105,259,184	1930	90,545	1163	1,561,044	17.24	1.48	33,047,670	21.17	1 to 67

GENERAL HOSPITALS OF 100 OR MORE BEDS

MORBIDITY BY STATES

TABLE 4

STATE	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Av. No. Patients	% Pop. Treated	Total [illegible] Treatment	Av. No. [illegible] Treat.	[illegible]
Alabama	2,395,270	6	918	2609	13,871	15	.58	335,123	24	1 to 173
Arizona	272,031	1	125	2176	2,844	23	1.05	[illegible]	16	96
Arkansas	1,792,965	3	450	3984	[illegible]	14	.36	164,282	25	278
California	3,119,412	35	6,918	451	121,757	18	3.90	2,525,240	21	26
Colorado	1,014,581	9	1,645	617	23,853	15	2.35	600,380	25	43
Connecticut	1,286,268	12	2,385	539	[illegible]	18	3.38	870,430	20	30
Delaware	216,941	2	400	542	[illegible]	16	3.01	146,054	22	33
Dist. of Columbia	374,584	10	1,943	193	30,019	15	8.01	709,049	24	12
Florida	938,877	2	215	4367	2,690	13	.28	78,494	29	349
Georgia	2,935,617	8	1,325	2216	28,064	21	[illegible]	483,543	17	105
Idaho	461,766	1	115	4015	1,656	14	.36	41,963	25	279
Illinois	6,317,734	51	11,025	573	207,270	19	3.28	4,023,111	19	31
Indiana	2,854,167	18	2,920	977	[illegible]	17	1.70	1,065,899	22	59
Iowa	2,224,771	11	2,223	1001	31,095	14	1.40	811,269	26	72
Kansas	1,874,195	4	794	2360	[illegible]	15	.63	289,878	24	158
Kentucky	2,408,547	9	1,675	1438	21,070	13	.87	611,241	29	114
Louisiana	1,884,778	6	2,204	855	35,727	16	1.90	804,572	23	53
Maine	782,191	5	633	1236	8,735	14	1.12	231,041	26	90
Maryland	1,384,539	13	2,912	475	40,501	14	2.92	1,062,746	26	34
Massachusetts	[illegible]	29	6,320	606	110,853	18	2.89	2,306,851	21	35
Michigan	3,133,678	15	3,405	920	56,182	17	1.79	1,242,746	22	56
Minnesota	2,345,287	18	4,061	578	63,595	16	2.71	1,482,399	23	37
Mississippi	2,001,466	3	350	5718	5,254	15	.26	127,777	24	381
Missouri	3,448,498	25	4,997	690	81,451	16	2.36	1,823,688	22	42
Montana	486,376	5	692	702	16,738	24	3.44	252,576	15	29
Nebraska	1,296,877	8	1,303	995	17,745	14	1.37	475,566	27	73
Nevada	[illegible]	None	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
New Hampshire	443,352	1	115	3881	1,572	14	.35	41,972	27	284
New Jersey	3,080,371	28	4,965	620	84,405	17	2.74	1,812,175	21	36
New Mexico	[illegible]	None	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
New York	10,646,989	87	22,828	466	388,304	17	3.65	8,333,004	21	27
North Carolina	2,466,025	4	462	5338	7,367	16	.30	168,557	23	335
North Dakota	791,437	2	270	2931	[illegible]	17	.57	98,556	22	176
Ohio	5,273,814	35	7,457	707	114,167	15	2.16	2,721,741	24	46
Oklahoma	2,377,629	1	130	18289	1,939	15	[illegible]	47,409	24	1,226
Oregon	888,243	3	750	1184	11,554	15	1.30	273,714	24	77
Pennsylvania	8,798,667	72	16,087	547	265,436	17	3.02	5,871,444	22	33
Rhode Island	637,415	3	784	813	12,309	16	1.93	286,184	23	52
South Carolina	1,660,934	4	563	2950	8,704	15	.52	205,501	24	191
South Dakota	735,431	1	100	7354	1,675	17	.23	36,498	22	439
Tennessee	2,321,253	7	1,298	1788	22,905	18	.99	473,675	21	101
Texas	4,601,279	17	2,855	1612	43,110	15	[illegible]	1,041,969	24	107
Utah	[illegible]	3	[illegible]	862	8,635	16	1.90	191,956	22	53
Vermont	[illegible]	1	130	2817	2,233	17	.61	47,451	21	164
Virginia	2,234,030	5	990	2257	17,216	17	.77	361,192	21	130
Washington	1,660,578	10	1,688	984	36,169	21	2.17	615,958	17	46
West Virginia	1,439,165	7	987	1458	15,358	16	1.07	360,299	23	94
Wisconsin	2,553,983	17	2,446	1040	38,068	16	1.49	893,075	23	67
Wyoming	[illegible]	None	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Totals	104,517,047	617	127,384	820	2,123,403	16.67	2.03	46,493,866	21.90	1 to 49

GENERAL HOSPITALS OF 25 OR MORE BEDS

MORBIDITY BY STATE GROUPS

SUMMARY OF TABLES (6) AND (7)

TABLE 5

GROUP	Population 1918 Census Estimate	No. Hospitals	Total No. Beds	No. Patients to One Bed	No. Patients Per Year	Av. No. Patients Per Bed	% Pop. Treated Per Yr.	Total No. Days' Treatment	Av. No. Days' Treatment	Ratio Patients to Pop.
New England	7,351,208	213	17,920	410	306,771	17	4.17	6,540,987	21	1 to 24
Middle Atlantic	28,174,686	699	75,610	372	1,269,318	17	4.51	27,598,311	22	22
Southern	25,376,093	374	24,336	1043	408,008	17	1.61	8,882,151	22	62
Central	35,258,422	917	74,914	471	1,259,881	17	3.57	27,340,796	22	28
Western	9,098,775	344	25,149	362	440,469	18	4.84	9,179,291	21	21
Totals	105,259,184	2547	217,929	483	3,684,447	16.91	3.50	79,541,536	21.58	1 to 29

GENERAL HOSPITALS OF 25 TO 99 BEDS

MORBIDITY BY STATE GROUPS

TABLE 6

GROUP	Population 1918 Census Estimate	No. Hospitals	Total No. Beds	No. Patients to One Bed	No. of Patients Per Yr.	Av. No. Patients Per Bed	% Pop. Treated Per Yr.	Total No. Days' Treatment	Av. No. Days' Treat.	Ratio Patients to Pop.
New England	7,351,208	162	7,553	973	127,591	17	1.74	2,757,058	22	1 to 58
Middle Atlantic	28,174,686	475	24,498	1,150	421,550	17	1.50	8,942,348	21	67
Southern	25,376,093	313	13,566	1,870	231,927	17	.91	4,951,249	21	109
Central	35,258,422	703	32,238	1,094	562,713	17	1.60	11,765,129	21	63
Western	9,098,775	277	12,690	717	217,263	17	2.39	4,631,886	21	42
Totals	105,259,184	1930	90,545	1,163	1,561,044	17.24	1.48	33,047,670	21.17	1 to 67

GENERAL HOSPITALS OF 100 OR MORE BEDS

MORBIDITY BY STATE GROUPS

TABLE 7

GROUP	Population 1918 Census Estimate	No. Hospitals	Total No. Beds	No. Pop. to One Bed	No. Patients Per Yr.	Av. No. Patients Per Bed	% Pop. Treated Per Yr.	Total No. Days' Treatment	Av. No. Days' Treat.	Ratio Patients to Pop.
New England	7,351,208	51	10,367	709	179,180	17	2.44	3,783,929	21	1 to 41
Middle Atlantic	28,174,686	224	51,112	551	847,768	17	3.01	18,655,963	22	33
Southern	25,376,093	61	10,770	2,356	176,081	16	.69	3,930,902	22	144
Central	35,258,422	214	42,676	826	697,168	16	1.98	15,575,667	22	51
*Western	8,356,638	67	12,459	671	223,206	18	2.67	4,547,405	20	37
Totals	104,517,047	617	127,384	820	2,123,403	16.67	2.03	46,493,866	21.90	1 to 49

*Note: The populations of Nevada, New Mexico, and Wyoming are not included. These states have no hospitals of 100 or more beds which fall within the survey.

GENERAL HOSPITALS OF 100 OR MORE BEDS

FINANCIAL DATA BY STATES

TABLE 8

STATE	Population 1945 Estimate	No. Hospitals	Total No. Beds	No. Patients Per Yr.	Expenditure Per Yr.	Per Patient	Per Bed	% of Pop.	Value	Per Bed
Alabama	2,395,270	6	918	13,871	$ 412,679	$29.75	$449.54	$ .17	$936,470	$1,020.12
Arizona	272,034	1	125	2,844	50,000	17.58	400.00	.18	165,000	1,320.00
Arkansas	1,792,965	3	450	6,450	[illegible]	34.61	[illegible]	.12	610,850	1,357.44
California	3,119,412	35	6,918	121,757	5,228,882	42.95	[illegible]	1.68	19,304,016	2,790.41
Colorado	1,014,581	9	1,645	23,853	689,255	28.90	419.00	.68	2,778,142	1,688.84
Connecticut	1,286,268	12	2,385	43,478	1,507,320	34.67	632.00	1.17	7,336,260	3,076.00
Delaware	216,941	2	400	6,529	171,214	26.22	[illegible]	.79	739,911	1,849.78
Dist. of Col.	374,584	10	1,943	30,019	981,817	32.70	505.31	2.62	4,102,858	2,111.61
Florida	938,877	2	215	2,690	93,845	34.89	[illegible]	.10	669,772	3,115.21
Georgia	2,935,617	8	1,325	28,064	646,820	23.05	488.16	.22	1,742,720	1,315.26
Idaho	461,766	1	115	1,656	33,833	20.43	294.20	.07	[illegible]	936.40
Illinois	6,317,734	51	11,025	207,270	6,993,158	33.74	[illegible]	1.11	33,393,623	3,028.90
Indiana	2,854,167	18	2,920	48,472	1,236,036	25.50	423.30	.43	5,621,584	1,925.20
Iowa	2,224,771	11	2,223	31,095	920,827	29.61	414.23	.41	4,220,421	[illegible]
Kansas	1,874,195	4	794	11,890	335,148	28.19	422.10	.18	1,485,000	1,870.28
Kentucky	2,408,547	9	1,675	21,070	923,439	43.83	551.31	.38	3,931,500	2,347.16
Louisiana	1,884,778	6	2,204	35,727	1,645,483	46.06	[illegible]	.87	4,346,376	1,972.04
Maine	782,191	5	633	8,735	328,337	37.59	518.70	.42	1,788,098	2,824.80
Maryland	1,384,539	13	2,912	40,501	2,242,113	55.35	[illegible]	1.62	8,980,086	3,083.82
Massachusetts	3,832,790	29	6,320	110,853	4,283,566	38.64	677.77	1.12	18,598,559	2,942.81
Michigan	3,133,678	15	3,405	56,182	3,374,355	60.06	991.00	1.08	6,842,347	2,009.50
Minnesota	2,345,287	18	4,061	63,595	2,606,147	40.98	641.75	1.11	8,042,567	1,980.44
Mississippi	2,001,466	3	350	5,254	138,188	26.30	394.82	.07	472,550	1,350.14
Missouri	3,448,498	25	4,997	81,451	2,627,822	32.26	525.88	.76	9,810,960	1,963.37
Montana	486,376	5	692	16,738	481,894	28.79	606.38	.99	1,198,051	1,731.29
Nebraska	1,296,877	8	1,303	17,745	523,978	29.52	402.13	.40	1,703,076	1,307.04
Nevada	.....	..	.....	.....	.....	.....	.....	.....	.....	.....
New Hampshire	446,352	1	115	1,572	40,728	25.91	[illegible]	.09	150,000	[illegible]
New Jersey	3,080,371	28	4,965	84,405	2,733,630	32.39	550.58	.89	9,640,044	1,941.60
New Mexico	.....	..	.....	.....	.....	.....	.....	.....	.....	.....
New York	10,646,989	87	22,828	388,304	15,723,698	40.48	688.79	1.48	[illegible]	3,414.14
North Carolina	2,466,025	4	462	7,367	181,476	24.63	393.65	.07	822,608	1,780.54
North Dakota	791,437	2	270	4,488	126,746	39.38	469.43	.16	349,630	1,294.93
Ohio	5,273,814	35	7,457	114,167	4,006,497	35.09	537.28	.76	22,177,416	2,974.04
Oklahoma	2,377,629	1	130	1,939	50,245	25.91	386.50	.02	300,000	2,307.69
Oregon	888,243	3	750	11,554	287,004	24.84	382.67	.32	1,452,130	1,936.17
Pennsylvania	8,798,067	72	16,087	265,436	9,359,417	35.30	581.80	1.06	41,679,808	2,590.90
Rhode Island	637,415	3	784	12,309	485,668	39.46	619.47	.76	2,269,068	2,894.22
South Carolina	1,660,934	4	563	8,704	280,632	32.24	498.46	.17	963,948	1,712.16
South Dakota	735,434	1	100	1,675	43,289	25.84	432.89	.06	125,000	1,250.00
Tennessee	2,321,253	7	1,298	22,905	588,294	25.68	453.23	.25	2,666,870	2,054.60
Texas	4,601,279	17	2,855	43,110	1,313,783	30.48	460.17	.29	5,452,365	1,909.76
Utah	453,648	3	526	8,635	420,520	48.70	799.46	.93	1,439,129	2,735.97
Vermont	366,192	1	130	2,233	82,977	37.16	638.28	.23	361,000	2,776.92
Virginia	2,234,030	5	990	17,216	488,347	28.37	493.28	.22	1,723,095	1,740.50
Washington	1,660,578	10	1,688	36,169	838,963	23.20	497.02	.51	3,842,624	2,276.44
West Virginia	1,439,165	7	987	15,358	404,927	26.37	410.26	.28	2,359,601	2,390.68
Wisconsin	2,553,983	17	2,446	38,068	1,297,677	34.09	528.37	.51	5,248,447	2,136.99
Wyoming	.....	..	.....	.....	.....	.....	.....	.....	.....	.....
Totals	104,517,047	617	127,384	2,123,403	$77,453,864	$36.48	$608.03	$ .74	$329,889,254	$2,589.72

GENERAL HOSPITALS OF 25 OR MORE BEDS

MORBIDITY BY PROVINCES

SUMMARY OF TABLES (10) AND (11)

TABLE 9

PROVINCE	Population 1918 Census Estimate	No. Hospitals	Total No. of Beds	No. Pop. to One Bed	No. Patients Per Yr.	Av. No. Patients Per Bed	% Pop. Treated Per Yr.	Total No. Days' Treatment	Av. No. of Days' Treat.	Ratio Patients to Pop.
Alberta	545,135	15	1191	458	26,265	22	4.82	431,164	17	1 to 21
British Columbia	549,080	20	1733	317	29,229	17	5.32	632,718	22	19
Manitoba	592,754	9	1585	374	36,066	23	6.08	578,446	16	16
New Brunswick	369,483	7	410	901	5,224	13	1.41	149,662	29	71
Nova Scotia	507,108	8	413	1228	5,600	14	1.10	150,712	27	91
Ontario	2,699,903	65	6334	426	82,588	13	3.06	2,312,156	28	33
Prince Ed. Isl.	89,979	2	90	1000	1,422	16	1.58	32,848	23	63
Quebec	2,202,983	22	3991	552	84,763	21	3.85	1,456,883	17	26
Saskatchewan	933,530	15	1184	788	19,185	16	2.05	432,156	23	49
Totals	8,489,955	163	16,931	501	290,315	17.14	3.41	6,154,678	21.20	1 to 29

GENERAL HOSPITALS OF 25 TO 99 BEDS

MORBIDITY BY PROVINCES

TABLE 10

PROVINCE	Population 1918 Census Estimate	No. Hospitals	Total No. Beds	No. Population One Bed	No. Patients Per Yr.	Av. No. Patients Per Bed	% Pop. Treated Per Yr.	Total No. Days' Treatment	Av. No. Days' Treat.	Prop. Patients to Pop.
Alberta	545,135	11	531	1027	9,410	18	1.73	193,846	21	1 to 55
British Columbia	549,080	15	599	917	9,934	17	1.81	218,647	22	50
Manitoba	592,754	4	210	2823	3,961	19	.67	76,645	19	151
New Brunswick	369,483	6	265	1394	3,339	13	.90	96,731	29	118
Nova Scotia	507,108	7	313	1620	4,300	14	.85	114,208	27	111
Ontario	2,699,903	45	2338	1155	26,684	11	.99	853,621	32	103
Prince Edw. Isl.	89,979	2	90	1000	1,422	16	1.58	32,848	23	65
Quebec	2,202,983	8	490	4496	9,007	18	.41	178,879	20	245
Saskatchewan	933,530	11	554	1685	8,864	16	.95	202,188	23	108
Totals	8,489,955	109	5390	1575	76,921	14.27	.91	1,967,613	25.58	1 to 110

GENERAL HOSPITALS OF 100 OR MORE BEDS

MORBIDITY BY PROVINCES

TABLE 11

PROVINCE	Population 1918 Census Estimate	No. Hospitals	Total No. Beds	Av. No. Pop. to One Bed	No. Patients Per Yr.	Av. No. Patients Per Bed	% Pop. Treated Per Yr.	Total No. Days' Treatment	Av. No. Days' Treat.	Ratio Patients to Pop.
Alberta	545,135	4	660	826	16,855	26	3.09	237,318	14	1 to 32
British Columbia	549,080	5	1,134	484	19,295	17	3.51	414,071	21	28
Manitoba	592,754	5	1,375	431	32,105	23	5.41	561,801	16	18
New Brunswick	369,483	1	145	2,548	1,885	13	.51	52,931	28	196
Nova Scotia	507,108	1	100	5,071	1,300	13	.26	36,504	28	390
Ontario	2,699,903	20	3,996	676	55,904	14	2.07	1,458,535	26	48
Prince Ed. Isl,	.....	None	....	....	.....	..	....	.....	..	..
Quebec	2,202,983	14	3,501	629	75,756	22	3.43	1,278,004	17	29
Saskatchewan	933,530	4	630	1,482	10,294	16	1.10	229,968	22	91
Totals	8,399,976	54	11,541	727	213,394	18.49	2.54	4,212,397	19.74	1 to 39

GENERAL HOSPITALS 100 OR MORE BEDS

GROUPED BY STATES AND PROVINCES

ALABAMA

Birmingham Infirmary, Birmingham
Hillman Hospital, Birmingham
Mobile City Hospital, Mobile
Saint Margaret's Hospital, Montgomery
Saint Vincent's Hospital, Birmingham
South Highlands Infirmary, Birmingham

ARIZONA

Saint Joseph's Hospital, Phoenix

CALIFORNIA

Agnew Sanitarium and Hospital, San Diego
Alameda County Hospital, San Leandro
Angelus Hospital Association, Los Angeles
Burnett Sanitarium, Fresno
California Hospital, Los Angeles
Children's Hospital, Los Angeles
Fabiola Hospital, Oakland
Fairmont Hospital, San Francisco
Franklin Hospital, San Francisco
French Hospital, San Francisco
Fresno County Hospital, Fresno
Good Samaritan Hospital, Los Angeles
Hospital for Children, San Francisco
Lane and Stanford University Hospitals, San Francisco
Los Angeles County Hospital, Los Angeles
Methodist Hospital of Southern California, Los Angeles
Mount Zion Hospital, San Francisco
O'Connor Sanitarium, San Jose
Pasadena Hospital, Pasadena
Providence Hospital, Oakland
Sacramento County Hospital, Sacramento
Saint Francis Hospital, San Francisco
Saint Joseph's Home and Hospital, Stockton
Saint Joseph's Hospital, San Francisco
Saint Joseph's Sanitarium, San Diego
Saint Luke's Hospital, San Francisco
Saint Mary's Hospital, San Francisco
Saint Vincent's Hospital, Los Angeles
Samuel Merritt Hospital, Oakland
San Diego County Hospital, San Diego
San Francisco Hospital, San Francisco
San Joaquin County Hospital, French Camp
Santa Clara County Hospital, San Jose
University of California Hospital, San Francisco

COLORADO

Denver City and County Hospital, Denver
Glockner General Hospital, Colorado Springs
Mercy Hospital, Denver
Saint Anthony's Hospital, Denver
Saint Francis Hospital, Colorado Springs
Saint Joseph's Hospital, Denver
Saint Luke's Hospital, Denver
Saint Mary's Hospital, Pueblo
Saint Raphael's Hospital, Trinidad

CONNECTICUT

Bridgeport Hospital, Bridgeport
Grace Hospital, New Haven
Greenwich General Hospital, Greenwich
Hartford Hospital, Hartford
New Britain Hospital, New Britain
New Haven Hospital, New Haven
Saint Francis Hospital, Hartford
Saint Mary's Hospital, Waterbury
Saint Raphael Hospital, New Haven
Saint Vincents Hospital, Bridgeport
Stamford Hospital, Stamford
Waterbury Hospital, Waterbury

DELAWARE

Delaware Hospital, Wilmington
Newcastle County Hospital, Farnhurst

DISTRICT OF COLUMBIA

Central Dispensary and Emergency Hospital, Washington
Children's Hospital, Washington
Columbia Hospital for Women, Washington
Freedmen's Hospital, Washington
George Washington University Hospital, Washington
Georgetown University Hospital, Washington
Garfield Memorial Hospital, Washington
Providence Hospital, Washington
Sibley Memorial Hospital, Washington
Washington Asylum, Hospital, Washington

FLORIDA

Pensacola Hospital, Pensacola
Saint Luke's Hospital, Jacksonville

GEORGIA

City Hospital, Columbus
Davis-Fischer Sanatorium, Atlanta
Georgia Baptist Hospital, Atlanta
Grady Memorial Hospital, Atlanta
Macon Hospital, Macon
Saint Joseph's Hospital, Savannah
Saint Joseph's Infirmary, Atlanta
University Hospital, Augusta

IDAHO

Saint Alphonsus Hospital, Boise

ILLINOIS

Alexian Brothers Hospital, Chicago
American Hospital, Chicago
Augustana Hospital, Chicago
Brokaw Hospital, Bloomington
Chicago Lying-In Hospital and Dispensary, Chicago
Children's Memorial Hospital, Chicago
Columbus Hospital, Chicago
Columbus Extension Hospital, Chicago
Cook County Hospital, Chicago

Englewood Hospital, Chicago
Evanston Hospital, Evanston
Frances E. Willard National Temperance Hospital, Chicago
Grant Hospital, Chicago
Hahnemann Hospital, Chicago
Illinois Central Hospital, Chicago
Illinois Charitable Eye and Ear Infirmary, Chicago
John C. Proctor Hospital, Peoria
Lake View Hospital, Danville
Mercy Hospital, Chicago
Michael Reese Hospital, Chicago
Norwegian American Hospital, Chicago
Oak Park Hospital, Oak Park
Presbyterian Hospital, Chicago
Rockford Hospital, Rockford
Saint Anne's Hospital, Chicago
Saint Anthony de Padua Hospital, Chicago
Saint Anthony's Hospital, Effingham
Saint Anthony's Hospital, Rockford
Saint Bernard's Hospital, Chicago
Saint Elizabeth's Hospital, Belleville
Saint Elizabeth's Hospital, Chicago
Saint Elizabeth's Hospital, Danville
Saint Francis Hospital, Litchfield
Saint Francis Hospital, Peoria
Saint John's Hospital, Springfield
Saint Joseph's Hospital, Bloomington
Saint Joseph's Hospital, Chicago
Saint Joseph's Hospital, Joliet
Saint Luke's Hospital, Chicago
Saint Mary's Hospital, Decatur
Saint Mary's Hospital, East Saint Louis
Saint Mary's Hospital, Quincy
Saint Mary's Hospital, Streator
Saint Mary's Hospital, Cairo
Saint Mary of Nazareth Hospital, Chicago
Springfield Hospital, Springfield
Swedish Covenant Hospital and Home of Mercy, Chicago
Washington Park Hospital, Chicago
Wesley Memorial Hospital, Chicago
West Side Hospital, Chicago
West Suburban Hospital, Oak Park

INDIANA

Ft. Wayne Lutheran Hospital, Ft. Wayne
Hope Methodist Hospital, Ft. Wayne
Indianapolis City Hospital, Indianapolis
LaFayette Home Hospital, LaFayette
Methodist Episcopal Hospital and Deaconess Home, Indianapolis
Protestant Deaconess Hospital, Indianapolis
Robert W. Long Hospital, Indianapolis
Saint Anthony's Hospital, Terre Haute
Saint Edward's Hospital, New Albany
Saint Elizabeth's Hospital, LaFayette
Saint Francis Hospital, Indianapolis
Saint John's Hospital, Anderson
Saint Joseph's Hospital, Ft. Wayne
Saint Joseph's Hospital, Mishawaka
Saint Margaret's Hospital, Hammond
Saint Mary's Hospital, Evansville
Saint Mary's Mercy Hospital, Gary
Saint Vincent's Hospital, Indianapolis

IOWA

Iowa Lutheran Hospital, Des Moines
Iowa Methodist Hospital, Des Moines
Mercy Hospital, Council Bluffs
Mercy Hospital, Davenport
Mercy Hospital, Des Moines
Saint Anthony's Hospital, Carroll
Saint Francis Hospital, Waterloo
Saint Joseph's Mercy Hospital, Dubuque
Saint Joseph's Mercy Hospital, Sioux City
Saint Vincent's Hospital, Sioux City
University Hospital, Iowa City

KANSAS

Bethany Methodist Hospital, Kansas City
Saint Francis Hospital, Wichita
Saint Margaret's Hospital, Kansas City
Wichita Hospital and Training School, Wichita

KENTUCKY

Good Samaritan Hospital, Lexington
John N. Norton Memorial Infirmary, Louisville
Louisville City Hospital, Louisville
Saint Anthony's Hospital, Louisville
Saint Elizabeth's Hospital, Covington
Saint Joseph's Hospital, Lexington
Saint Joseph's Infirmary, Louisville
Saints Mary and Elizabeth Hospital, Louisville
Speers Memorial Hospital, Dayton

LOUISIANA

Charity Hospital, New Orleans
French Hospital, New Orleans
Hotel Dieu, New Orleans
Saint Francis Sanitarium, Monroe
T. E. Schumpert Memorial Sanitarium, Shreveport
Touro Infirmary, New Orleans

MAINE

Central Maine General Hospital, Lewiston
Eastern Maine General Hospital, Bangor
Maine Eye and Ear Hospital, Portland
Maine General Hospital, Portland
Saint Mary's General Hospital, Lewiston

MARYLAND

Allegheny Hospital of the Sisters of Charity, Cumberland
Bay View City Hospital, Baltimore
Church Home and Infirmary, Baltimore
Franklin Square Hospital, Baltimore
Hebrew Hospital and Asylum, Baltimore
Hospital for Women of Maryland, Baltimore
Johns Hopkins Hospital, Baltimore
Maryland General Hospital, Baltimore
Mercy Hospital, Baltimore
Saint Agnes Sanitarium, Baltimore
Saint Joseph's Hospital, Baltimore
Union Protestant Infirmary, Baltimore
University Hospital, Baltimore

MASSACHUSETTS

Boston City Hospital, Boston
Burbank Hospital, Fitchburg
Cambridge Hospital, Cambridge
Carney Hospital, Boston
Children's Hospital, Boston
City Hospital, Fall River
Cooley-Dickinson Hospital, Northampton
Holyoke City Hospital, Holyoke
House of Mercy Hospital, Pittsfield
Lawrence General Hospital, Lawrence
Lowell Corporation Hospital, Lowell
Lowell General Hospital, Lowell
Lynn Hospital, Lynn
Massachusetts Charitable Eye and Ear Hospital, Boston
Massachusetts General Hospital, Boston

Massachusetts Homeopathic Hospital, Boston
Memorial Hospital, Worcester
Mercy Hospital, Springfield
New England Hospital for Women and Children, Boston
Newton Hospital, Newton Lower Falls
Peter Bent Brigham Hospital, Boston
Saint Elizabeth's Hospital, Brighton
Saint Luke's Hospital, Bedford
Saint Vincent Hospital, Worcester
Salem Hospital, Salem
Springfield Hospital, Springfield
Union Hospital, Fall River
Waltham Hospital, Waltham
Worcester City Hospital, Worcester

MICHIGAN

Battle Creek Sanitarum (Michigan Sanitarium and Benevolent Association), Battle Creek.
Blodgett Memorial Hospital, Grand Rapids
Borgess Hospital, Kalamazoo
Butterworth Hospital, Grand Rapids
Detroit Receiving Hospital, Detroit
Grace Hospital, Detroit
Harper Hospital, Detroit
House of Providence, Detroit
Hurley Hospital, Flint
Saint Mary's Hospital, Detroit
Saint Mary's Hospital, Grand Rapids
University Hospital, Ann Arbor
University of Michigan Homeopathic Hospital, Ann Arbor
W. E. Foot Memorial Hospital, Jackson
Women's Hospital and Infants' Home, Detroit

MINNESOTA

Asbury Methodist Deaconess Hospital, Minneapolis
Bethesda Hospital, St. Paul
City and County Hospital, St. Paul
Eitel Hospital, Minneapolis
Minneapolis City Hospital, Minneapolis
Mounds Park Sanitarium, St. Paul
Northwestern Hospital, Minneapolis
Saint Barnabas Hospital, Minneapolis
Saint Joseph's Hospital, Duluth
Saint Luke's Hospital, Duluth
Saint Luke's Hospital, St. Paul
Saint Mary's Hospital, Duluth
Saint Mary's Hospital, Minneapolis
Saint Mary's Hospital, Rochester
Saint Paul Hospital, St. Paul
Swedish Hospital, Minneapolis
United Church Hospital Association, Fairview
University of Minnesota Hospital, Minneapolis

MISSISSIPPI

Matty Hersee Hospital, Meridian
Natchez Charity Hospital, Natchez
Vicksburg Sanitarium, Vicksburg

MISSOURI

Alexian Brothers Hospital, St. Louis
Barnes Hospital, St. Louis
Centenary Hospital, St. Louis
Christian Church Hospital, Kansas City
Deaconess Home and Hospital Association, St. Joseph
Evangelical Deaconess Home and Hospital, St. Louis
Grace Hospital, Kansas City
Jewish Hospital, St. Louis
Kansas City General Hospital, Kansas City
Missouri Baptist Sanitarium, St. Louis
Mullanphy Hospital, St. Louis
Noyes Memorial Hospital, St. Joseph
Research Hospital, Kansas City
Saint Anthony's Hospital, St. Louis
Saint John's Hospital, Joplin
Saint John's Hospital, Springfield
Saint John's Hospital, St. Louis
Saint Joseph's Hospital, Kansas City
Saint Joseph's Hospital, St. Joseph
Saint Louis Children's Hospital, St. Louis
Saint Louis City Hospital, St. Louis
Saint Luke's Hospital, St. Louis
Saint Mary's Infirmary, St. Louis
Saint Mary's Hospital, Kansas City
Wesley Hospital, Kansas City

MONTANA

Columbus Hospital, Great Falls
Montana Deaconess Hospital, Great Falls
Murray Hospital, Butte
Saint James Hospital, Butte
Saint Patrick's Hospital, Missoula

NEBRASKA

Creighton Memorial Saint Joseph's Hospital, Omaha
Douglas County Hospital, Omaha
Lincoln Sanitarium, Lincoln
Nebraska Methodist Hospital and Deaconess Home, Omaha
Saint Elizabeth's Hospital, Lincoln
Saint Francis Hospital, Grand Island
Saint Mary's Hospital, Columbus
University of Nebraska Hospital, Omaha

NEW HAMPSHIRE

Saint Joseph's Hospital, Nashua

NEW JERSEY

Alexian Brothers Hospital, Elizabeth
Atlantic City Hospital, Atlantic City
Bayonne Hospital and Dispensary, Bayonne
Christ Hospital, Jersey City
Cooper Hospital, Camden
Elizabeth General Hospital and Dispensary, Elizabeth
Hackensack Hospital, Hackensack
Jersey City Hospital, Jersey City
Mercer Hospital, Trenton
Monmouth Memorial Hospital, Long Branch
Morristown Memorial Hospital, Morristown
Mountainside Hospital, Montclair
Muhlenberg Hospital, Plainfield
Newark Beth Israel Hospital, Newark
Newark City Hospital, Newark
Orange Memorial Hospital, Orange
Passaic General Hospital, Passaic
Paterson General Hospital Paterson
Saint Barnabas Hospital, Newark
Saint Elizabeth's Hospital, Elizabeth
Saint Francis Hospital, Jersey City
Saint Francis Hospital, Trenton
Saint Joseph's Hospital, Paterson
Saint Mary's Hospital, Hoboken
Saint Mary's Hospital, Orange
Saint Michaels Hospital, Newark
Saint Peters General Hospital, New Brunswick
West Jersey Homeopathic Hospital, Camden

NEW YORK

Albany Hospital, Albany
Arnot-Ogden Memorial Hospital, Elmira
Auburn City Hospital, Auburn

Bellevue Hospital, New York
Beth Israel Hospital, New York
Binghamton City Hospital, Binghamton
Brooklyn Hospital, Brooklyn
Buffalo General Hospital, Buffalo
[illegible] Hospital, Buffalo
[illegible] Hospital of the Sisters of Charity, Buffalo
Children's Hospital, Buffalo
Coney Island Hospital, Brooklyn
Crouse-Irving Hospital, Syracuse
Cumberland Street Hospital, Brooklyn
Ellis Hospital, Schenectady
Erie County Hospital, Buffalo
Flower Hospital, New York
Flushing Hospital and Dispensary, Flushing
Fordham Hospital, New York
French Benevolent Society Hospital, New York
General Memorial Hospital, New York
German Deaconess Home and Hospital, Buffalo
Gouverneur Hospital, New York
Greenpoint Hospital, Brooklyn
Hahnemann Hospital of the City of New York, New York
Hahnemann Hospital, Rochester
Harlem Hospital, New York
Homeopathic Hospital, Albany
Hospital of Good Shepherd, Syracuse
Italian Benevolent Hospital, New York
Jewish Hospital, Brooklyn
Kings County Hospital, Brooklyn
Lebanon Hospital, New York
Lenox Hill Hospital, New York
Lincoln Hospital, New York
Long Island College Hospital, Brooklyn
Lying-In Hospital, New York
Manhattan Eye and Ear Hospital, New York
Maternity Hospital, Albany
Methodist Episcopal Hospital, Brooklyn
Metropolitan Hospital, New York
Misericordia Hospital, New York
Mount Saint Mary's Hospital, Niagara Falls
Mount Sinai Hospital, New York
Mount Vernon Hospital, Mount Vernon
New York City Hospital, Blackwells Island, New York
New York Eye and Ear Infirmary, New York
New York Hospital, New York
New York Infirmary for Women and Children, New York
New York Nursery and Children's Hospital, New York
New York Ophthalmic Hospital, New York
New York Orthopedic Hospital, New York
New York Polyclinic Hospital, New York
New York Post Graduate Medical School and Hospital, New York
New York Skin and Cancer Hospital, New York
New York Society for the Relief of Ruptured and Crippled, New York
Niagara Falls Memorial Hospital, Niagara Falls
Norwegian Lutheran Deaconess Home and Hospital, Brooklyn
O. E. Jones General Hospital, Jamestown
Oneida County Hospital, Rome
Presbyterian Hospital, New York
Rochester General Hospital, Rochester
Rochester Homeopathic Hospital, Rochester
Roosevelt Hospital, New York
Saint Agnes Hospital, White Plains
Saint Catharine Hospital, Brooklyn
Saint Francis Hospital, New York
Saint Johns Brooklyn Hospital, Brooklyn
Saint John's Hospital, Long Island
Saint Johns Riverside Hospital, Yonkers
Saint Joseph Syracuse Hospital, Syracuse
Saint Luke's Hospital, New York
Saint Luke's Hospital, Utica
Saint Mary's Hospital, Brooklyn
Saint Mary's Hospital, New York
Saint Mary's Hospital, Rochester
Saint Peters Hospital, Albany
Saint Peters Hospital, Brooklyn
Saint Vincent's Hospital, New York
Saint Vincent's Hospital, West New Brighton
Samaritan Hospital, Troy
Seton Hospital, New York
Sloane Hospital for Women, New York
Staten Island Hospital, Tompkinsville
Syracuse Women's and Children's Hospital, Syracuse
Troy Hospital, Troy
Women's Hospital, New York
Wyckoff Heights Hospital, Brooklyn

NORTH CAROLINA

James Walker Memorial Hospital, Wilmington
Presbyterian Hospital, Charlotte
Rex Hospital, Raleigh
Watts Hospital, West Durham

NORTH DAKOTA

Bismarck Evangelical Hospital, Bismarck
Saint Alexius Hospital, Bismarck

OHIO

Bethesda Hospital, Cincinnati
Christ Hospital, Cincinnati
Cincinnati General Hospital, Cincinnati
City Hospital of Akron, Akron
City Hospital, Springfield
Cleveland City Hospital, Cleveland
Elyria Memorial Hospital, Elyria
Good Samaritan Hospital, Cincinnati
Good Samaritan Hospital, Zanesville
Grant Hospital, Columbus
Hawkes Hospital of Mount Carmel, Columbus
Jewish Hospital, Cincinnati
Lakeside Hospital, Cleveland
Lucas County Hospital, Toledo
Miami Valley Hospital, Dayton
Mercy Hospital, Hamilton
Mount Sinai Hospital, Cleveland
Ohio Valley Hospital, Steubenville
People's Hospital, Akron
Protestant Hospital, Columbus
Saint Alexis Hospital, Cleveland
Saint Elizabeth's Hospital, Dayton
Saint Elizabeth's Hospital, Youngstown
Saint Francis Hospital, Cincinnati
Saint Francis Hospital, Columbus
Saint John's Hospital, Cleveland
Saint Joseph's Charity Hospital, Lorain
Saint Joseph's Maternity Hospital, Cincinnati
Saint Luke's Hospital, Cleveland
Saint Mary's Hospital, Cincinnati
Saint Ritas Hospital, Lima
Saint Vincent's Charity Hospital, Cleveland
Saint Vincent's Hospital, Toledo
Toledo Hospital, Toledo
Youngstown Hospital, Youngstown

OKLAHOMA

Saint Anthony's Hospital, Oklahoma City

OREGON

Good Samaritan Hospital, Portland
Sacred Heart Hospital, Medford
Saint Vincent's Hospital, Portland

PENNSYLVANIA

Allegheny General Hospital, Pittsburgh
Allentown Hospital, Allentown
Altoona Hospital, Altoona
Braddock General Hospital, Braddock
Bradford Hospital, Bradford
Chester County Hospital, West Chester
Chester Hospital, Chester
Children's Homeopathic Hospital, Philadelphia
Children's Hospital, Pittsburgh
Columbia Hospital, Pittsburgh
Conemaugh Valley Memorial Hospital, Johnstown
Easton Hospital, Easton
Elizabeth Steel Magee Hospital, Pittsburgh
Germantown Dispensary and Hospital, Philadelphia
Good Samaritan Hospital, Lebanon
Hahnemann Hospital, Scranton
Hahnemann Medical College Hospital, Philadelphia
Hamot Hospital, Erie
Harrisburg Hospital, Harrisburg
Homeopathic Medical and Surgical Hospital, Pittsburgh
Hospital of Protestant Episcopal Church, Philadelphia
Hospital of the University of Pennsylvania, Philadelphia
Hospital of the Women's Homeopathic Association of Pennsylvania, Philadelphia
Jefferson Medical College Hospital, Philadelphia
Jewish Hospital, Philadelphia
Lancaster General Hospital, Lancaster
Lankenau Hospital, Philadelphia
McKeesport Hospital, McKeesport
Medico Chirurgical Hospital, Philadelphia
Mercy Hospital, Johnstown
Mercy Hospital, Pittsburgh
Mercy Hospital, Wilkes Barre
Methodist Episcopal Hospital, Philadelphia
Misericordia Hospital, Philadelphia
Moses Taylor Hospital, Scranton
Passavant Hospital, Pittsburgh
Pennsylvania Hospital, Philadelphia
Philadelphia General Hospital, Philadelphia
Philadelphia Orthopedic Hospital, Philadelphia
Philadelphia Polyclinic Hospital, Philadelphia
Pittsburgh Hospital, Pittsburgh
Pottsville Hospital, Pottsville
Presbyterian Hospital, Pittsburgh
Presbyterian Hospital, Philadelphia
Reading Hospital, Reading
Robert Packer Hospital, Sayre
Saint Agnes Hospital, Philadelphia
Saint Francis Hospital, Pittsburgh
Saint John's General Hospital, Pittsburgh
Saint Joseph's Hospital, Lancaster
Saint Joseph's Hospital, Philadelphia
Saint Joseph's Hospital, Reading
Saint Joseph's Hospital and Dispensary, Pittsburgh
Saint Luke's Hospital, South Bethlehem
Saint Margaret's Memorial Hospital, Pittsburgh
Saint Mary's Hospital, Philadelphia
Saint Timothy's Memorial Hospital, Philadelphia
Saint Vincent's Hospital, Erie
Samaritan Hospital, Philadelphia
Shenango Valley Hospital, New Castle
South Side Hospital, Pittsburgh
State Hospital of Middle Coal Fields, Hamilton
State Hospital for Injured Persons, Fountain Springs
Uniontown Hospital, Uniontown
Western Pennsylvania Hospital, Pittsburgh
Williamsport Hospital, Williamsport
Wilkes-Barre City Hospital, Wilkes-Barre
Wills Eye Hospital, Philadelphia
Women's Hospital, Philadelphia
York Hospital and Dispensary, York

RHODE ISLAND

Newport Hospital, Newport
Rhode Island Hospital, Providence
Saint Joseph's Hospital, Providence

SOUTH CAROLINA

Columbia Hospital, Columbia
Florence Infirmary, Florence
Roper Hospital, Charleston
South Carolina Baptist Hospital, Columbia

SOUTH DAKOTA

Saint Luke's Hospital, Aberdeen

TENNESSEE

Baptist Memorial Hospital, Memphis
Baroness Erlanger Hospital, Chattanooga
Knoxville General Hospital, Knoxville
Memphis General Hospital, Memphis
Nashville City Hospital, Nashville
Saint Joseph's Hospital, Memphis
Saint Thomas Hospital, Nashville

TEXAS

Baptist Sanitarium and Hospital, Houston
Doctor Kenney's Sanitarium, San Antonio
Hotel Dieu, Beaumont
Hotel Dieu, El Paso
John Sealy Hospital, Galveston
Parkland City Hospital, Parkland
Providence Sanitarium, Waco
Robert B. Green Memorial Hospital, San Antonio
Saint Joseph's Infirmary, Ft. Worth
Saint Joseph's Infirmary, Houston
Saint Joseph's Infirmary, Paris
Saint Mary's Infirmary, Galveston
Saint Paul's Sanitarium, Dallas
Saint Vincent's Hospital, Sherman
Santa Rosa Infirmary, San Antonio
Seton Infirmary, Austin
Temple Sanitarium, Temple
Texas Baptist Memorial Sanitarium, Dallas

UTAH

Doctor W. H. Groves' Latter Day Saints Hospital, Salt Lake City
Holy Cross Hospital, Salt Lake City
Saint Marks Hospital, Salt Lake City

VERMONT

Mary Fletcher Hospital, Burlington

VIRGINIA

Memorial Hospital, Richmond
Norfolk Protestant Hospital, Norfolk
Saint Vincent's Hospital and Sanitarium, Norfolk
University of Virginia Hospital, Charlottesville
Virginia Hospital, Richmond

WASHINGTON

King County Hospital, Seattle
Providence Hospital, Seattle

Sacred Heart Hospital, Spokane
Saint Elizabeth's Hospital, North Yakima
Saint Joseph's Hospital, Bellingham
Saint Joseph's Hospital, Tacoma
Saint Joseph's Hospital, Vancouver
Seattle General Hospital, Seattle
Swedish Hospital, Seattle
Tacoma General Hospital, Tacoma

WEST VIRGINIA

Charleston General Hospital, Charleston
City Hospital, Martinsburg
Mason Hospital, Clarksburg
Ohio Valley General Hospital, Wheeling
Saint Mary's Hospital, Clarksburg
Sheltering Arms Hospital, Hansford
Wheeling Hospital, Wheeling

WISCONSIN

La Crosse Lutheran Hospital, La Crosse
Luther Hospital, Eau Claire
Madison General Hospital, Madison
Milwaukee County Hospital, Wauwatosa
Milwaukee Hospital, Milwaukee
Pennoyer Sanitarium, Kenosha
Sacred Heart Hospital, Eau Claire
Saint Agnes Hospital, Fond du Lac
Saint Francis Hospital, La Crosse
Saint Joseph's Hospital, Chippewa Falls
Saint Joseph's Hospital, Ashland
Saint Joseph's Hospital, Milwaukee
Saint Mary's Hospital, Green Bay
Saint Mary's Hospital, Milwaukee
Saint Mary's Hospital, Superior
Saint Vincent's Hospital, Green Bay
Trinity Hospital, Milwaukee

ALBERTA

Calgary General Hospital, Calgary
Holy Cross General Hospital, Calgary
Medicine Hat General Hospital, Medicine Hat
Royal Alexandra Hospital, Edmonton

BRITISH COLUMBIA

Provincial Royal Jubilee Hospital, Victoria
Royal Columbian Hospital, New Westminster
Royal Inland Hospital, Kamloops
St. Joseph's Hospital, Victoria
St Paul's Hospital, Vancouver
Vancouver General Hospital, Vancouver

MANITOBA

Brandon General Hospital, Brandon
Misericordia Hospital, Winnipeg
St. Boniface Hospital, St. Boniface
Victoria Hospital, Winnipeg
Winnipeg General Hospital, Winnipeg

NEW BRUNSWICK

General Public Hospital, St. John

NOVA SCOTIA

St. Joseph's Hospital, Glace Bay

QUEBEC

Catholic Maternity Hospital, Montreal
Children's Memorial Hospital, Montreal
Crèche de la Miséricorde, Montreal
Hospice du Sacre Cœur, Sherbrooke
Hospital General St. Vincent de Paul, Sherbrooke
Hôtel Dieu de Sacre Cœur de Jesus, St. Sauveur de Quebec
Hôtel Dieu de St. Joseph, Arthabaska
Hôtel Dieu de St. Joseph, Montreal
Jeffery Hale's Hospital, Quebec
Quebec General Hospital, Quebec
Montreal General Hospital, Montreal
Notre Dame Hospital, Montreal
Royal Victoria Hospital, Montreal
Western Hospital, Montreal

SASKATCHEWAN

Grey Nuns' Hospital, Regina
Saint Paul's Hospital, Saskatoon
Saskatoon City Hospital, Saskatoon
Regina General Hospital, Regina

ONTARIO

Brantford General Hospital, Brantford
County Charleton General Hospital, Ottawa
General Hospital, Sault Ste. Marie
Grace Hospital, Toronto
Guelph General Hospital, Guelph
Hamilton City Hospital, Hamilton
Hospital for Sick Children, Toronto
Hotel Dieu Hospital, Kingston
House of Providence Hospital, Toronto
Kingston General Hospital, Kingston
McKellar General Hospital, Fort William
Misericordia Maternity Hospital, Ottawa
Ottawa General Hospital, Ottawa
Saint Joseph's Hospital, Hamilton
Saint Joseph's Hospital, London
Saint Joseph's Hospital, Port Arthur
Saint Joseph's General Hospital, Sudbury
Saint Luke's General Hospital, Ottawa
Saint Michael's Hospital, Toronto
Saint Vincent de Paul Hospital, Brockville
Toronto General Hospital, Toronto
Toronto Western Hospital, Toronto
Victoria General Hospital, London

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